Gynaecological Oncology News

Prof. Andreas Obermair — November 2007

Follow-up for Uterine Cancer

Early diagnosis of recurrence is critical

Below are the results of an important study presented our group published recently *[please email me for a copy]* and presented at the Annual Scientific Meeting of the College of O+G at the Gold Coast last month.

While we aim to detect recurrence of uterine cancer when the tumour volume is smallest and treatment thought to be effective, no study has shown yet that regular follow-up improves survival.

We analysed the data of 280 patients who developed uterine cancer recurrence. The main results:

- 70% of patients with recurrence present with symptoms, while only 30% were asymptomatic.
- Symptoms pointing to recurrence were pain, bleeding, palpation of a mass and urinary frequency.
- Asymptomatic patients had better survival following treatment of recurrence than symptomatic patients. This survival benefit was limited to patients with endometrioid endometrial adenocarcinoma but did not apply to patients with high-risk cell types such as clear-cell cancers or uterine papillary serous cancer (UPSC).
- The majority of all recurrences were distant (lung, liver), followed by the involvement of the vaginal vault.
- The important investigations leading to the detection of recurrence were internal examination, imaging, serum CA125 and vaginal vault cytology (smear) [in this order].

This is the first report world-wide suggesting that early diagnosis of asymptomatic recurrence might directly lead to a survival benefit.

If patients complain about warning signs (pain, bleeding) of recurrence, they need to see a doctor straight away. If symptoms suggest the possibility of recurrence, a CT scan of pelvis-abdomen and chest should be performed at the earliest convenience.

Clinical examination rather than vault smears or tumour markers should be performed on a regular basis to detect recurrence early.

Tumour Markers

CA-125 plus ultrasound identify suspicious pelvic masses

Returning from the Conference of the European Society of Gynaecological Oncology in Berlin I would like to give you an update on the most recent developments on the diagnosis of ovarian cancer.

Two thirds of patients with ovarian cancer are diagnosed at advanced stages, thus indicating generally poor prognosis. If more women could be shifted into early stages, outcomes would improve drastically.

CA-125 is a marker expressed by mesenchymal cells (peritoneum, pleura, pericard) and any process in these tissues can cause elevations in serum CA-125 (inflammation, pulmonary embolus, pericarditis, etc.). In contrast, only half of patients with stage 1 ovarian cancer will have serum CA-125 greater than 35 U/ml. In premenopausal women, we often tolerate higher cut-off values (65 U/ml) as benign cysts or endometriosis can cause elevations of CA-125 in a high number of women.

Ultrasound is essential to determine sonographic features of a pelvic mass (simple or complex, i.e. septations, solid components). Simple cysts carry a risk of malignancy risk of 1% or less and do not necessarily be investigated surgically (unless causing symptoms). Ultrasound alone can miss ovarian cancer as it is based on size and morphology and cancers may escape those criteria.

"The accuracy of ultrasound plus CA-125 is much higher than ultrasound alone in triaging suspicious pelvic masses"

The number of operations required to diagnose one case of ovarian cancer correctly was 36 in the ultrasound group and only 2.6 in the group of patients who had ultrasound plus CA-125. After an initial trial period the same number dropped to 11 for the "ultrasound only" group, thus indicating the importance of skills required to provide high-quality ultrasound reports.

"If screening decreases ovarian cancer mortality (still to be shown) it will be done through a combination of ultrasound plus serum CA-125". Prof. Ian Jacobs, UKCTOCS Trial

Merry Christmas and a Fantastic New Year to you all! I hope that we will continue working together in 2008.

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